vascular disease or diabetes) should have LDL-C levels <2.5 mmol/L. Canadians at very high risk and with high blood lipid levels would require an LDL-C reduction of at least 47% to achieve treatment goal. Of marketed statins, only moderate to high doses of atorvastatin (20, 40 and 80 mg), simvastatin (80 mg) or lovastatin (80 mg) could achieve the LDL-C reduction required by Canadian guidelines. In contrast, a new lipid-lowering agent (rosuvastatin) could achieve a 47% LDL-C reduction at the 10 mg dose. **CONCLUSIONS:** A significant proportion of Canadians should receive aggressive lipid-lowering therapy, which can only be achieved with higher doses of currently marketed statins to achieve Canadian treatment goals. Newer statins such as rosuvastatin would assist in achieving the updated treatment goals. By achieving these targets at lower doses, rosuvastatin can improve ease and success of management of hyperlipidemia.

PCV58

RANDOMIZED CONTROLLED INTERVENTION IN CARDIOVASCULAR DRUG TREATMENT IN NURSING HOMES

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OBJECTIVE: The aim of this study was to evaluate intervention of drug treatment to elderly patients with cardiovascular diseases living in nursing homes and assess the effect of this intervention. **METHOD:** Eighty patients living in nursing homes in the County of Stockholm were randomized into 2 groups, 43 to the intervention group (average age 87 years) and 37 to the control group (average age 85 years). Patients included had diagnoses of heart failure, post myocardial infarction or cardiac valvular disease. Patients with drug treatment related to these diagnoses were also included. At a first visit a research nurse interviewed each patient to collect data of symptoms and health-related quality of life. The drug therapy was recorded. After reviewing medication, specialists in clinical pharmacology and cardiology suggested changes in the cardiovascular drug therapy to the responsible physician. At each following visit the current drug therapies as well as data of symptoms and health-related quality of life were recorded. **RESULTS:** The outcome was measured as scores of symptoms. Changes of total Health Index, ADL scores and deaths were recorded as well. The patients in the intervention group initially consumed 9.8 drugs on the average. For the control group this figure was 9.2 drugs. A change of cardiovascular drug therapy was suggested for 40 patients. Thirty-two changes in 19 patients were carried out, mainly regarding furosemide and potassium. Suggestions to initiate treatment with ACE-inhibitors were never followed. There were no significant changes in the scores of symptoms, total Health Index or ADL scores. **CONCLUSIONS:** The self-reported symptoms for each patient were helpful as a guide for the specialists to evaluate the drug therapy. The intervention resulted in reduction of drug use in half of the patients in the intervention group without any negative effects on health of symptoms.

GASTROINTESTINAL DISEASES/DISORDERS—Economic Outcomes

PGS1

EMPLOYMENT LOSSES RELATED TO INFLAMMATORY BOWEL DISEASE IN THE UNITED STATES: RESULTS FROM THE NATIONAL INTERVIEW SURVEY

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OBJECTIVES: U.S. studies using varying methodologies have reported different estimates for the indirect cost per person with IBD. Our analysis contributes to this literature, by using the 1999 sample of the National Health Interview Survey (NHIS) to estimate the employment effect of Inflammatory Bowel Disease (IBD) in the United States. **METHODS:** Our predictive analysis adapts the theory of labor supply to a health context. A weighted logistic regression model was used to estimate the odds ratio (OR) of being out of the labor force as determined by predictive variables including having been diagnosed with IBD, with or without symptoms. Controls included demographic variables and health status indicators. For those people in the labor force, a second analysis was performed to determine whether an individual worked throughout the entire duration of the past 12 months or less than 12 months. SUDAAN 8.0 was used to generate population estimates, systematically correcting for survey design. **RESULTS:** Thirty-one and one-half percent of IBD patients who had experienced symptoms in the past 12 months reported being out of the labor force with OR = 2.07. We estimated the excess in the non-participation rate attributable to IBD with symptoms in the past 12 months in the United States to be 11.7%. Based on this, the indirect cost of non-participation attributable to IBD in 1998 was $3.5 billion US dollars or $4973 per person with IBD and symptoms. According to the second weighted logistic regression, having IBD had no association with the duration of work, for those who are in the labor force. Consequently, the indirect cost of IBD reported can be interpreted as the indirect cost of IBD associated with employment losses. **CONCLUSIONS:** By using directly observed data in our analysis, this method of estimation can be used to predict the overall paid-employment burden of IBD.